Supreme Court, U.S.
FILED
941280 JAN 25 1995
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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

CHARLES R. WILLMAN, M.D.,
Petitioner,

v.

HEARTLAND HOSPITAL EAST, *et al.*,
Respondents.

On Petition for Writ of Certiorari to the
United States Court of Appeals for the Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

This case concerns the application of federal antitrust laws and summary judgment standards to medical peer review. In a peer review, direct competitors of Petitioner, Charles R. Willman, M.D., determined his medical care to be substandard. They revoked his hospital privileges thereby excluding him from the practice of surgery at the only hospitals in the relevant market. In opposition to a motion for summary judgment, Dr. Willman presented substantial evidence disputing the legitimacy of the peer review and its conclusion that he gave substandard care. He presented economist's testimony that his exclusion, if unjustified on health care grounds, was anticompetitive and unreasonable. The district court granted summary judgment against him and the Eighth Circuit affirmed. The questions presented are:

I

Whether, under the Sherman Act, an appropriate Rule of Reason analysis requires resolution of the issue of the physician's competence or does the court's deference to the disputed peer review findings of competitors satisfy the Rule.

II

Whether, under *Matsushita* and *Kodak*, an unlawful conspiracy can reasonably be inferred from evidence that a physician was excluded after peer review by competitors who employed flawed methodologies and procedures, exceeded their authority, presented deceptive evidence, reached disputed medical conclusions, and imposed unreasonable sanctions.

LIST OF PARTIES

The Petitioner is:

Charles R. Willman, M.D.

The Respondents are:

Heartland Hospital East
Heartland Hospital West
Heartland Health System, Inc.
Richard Craig, M.D.
Ernest Weinand, M.D.
Edward Beheler, M.D.
Edward Andres, M.D.
James McMillen, M.D.
Robert Stuber, M.D.
Orlyn Lockard, Jr., M.D.
Charles Mullican, M.D.
Wallace McDonald, M.D.
Steven C. Krueger, M.D.

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Charles R. Willman, M.D. respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals, App. A, A1, is reported at 34 F.3d 605. The opinion of the district court, App. B, A16, is reported at 836 F.Supp. 1522.

JURISDICTION

The court of appeals entered its judgment on August 29, 1994, App. A, A1. On November 21, 1994, this Court extended the

time for filing a petition for a writ of certiorari to and including January 26, 1995. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTORY PROVISIONS INVOLVED

The statutes involved are 15 U.S.C. §§1, 2 and 15. They are set out in relevant part at App. C, A39.

STATEMENT OF THE CASE

A. The Parties And The Market Setting.

Charles R. Willman, M.D., F.A.C.S., is a board certified general surgeon who practiced surgery and medicine in St. Joseph, Missouri without restriction until 1981.[1] As the result of a series of peer review actions instigated in 1982 and pursued to completion in 1985 by rival physicians under the leadership of respondents, Dr. Willman lost his privileges at both St. Joseph area hospitals to admit patients or perform surgery.

The loss of his hospital privileges excluded him from the relevant service market of general surgical services in the St. Joseph, Missouri area, the relevant geographic market.[2] Only four board-certified general surgeons remained in the market after Dr. Willman's exclusion. His loss of privileges also excluded him as a competitor in other medical service markets such as internal medicine/family practice, urological and gynecological surgery and endoscopy.

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[1] Dr. Willman is duly licensed in Missouri as a physician. He has practiced in St. Joseph, Missouri his entire career. He is a graduate of Washington University School of Medicine, St. Louis; interned at St. Luke's Hospital, St. Louis; and completed a four-year residency in general surgery at Henry Ford Hospital, Detroit. He has served as chief of staff and in other positions of responsibility at the St. Joseph area hospitals.

[2] The St. Joseph area geographic market consists of the Missouri counties of Andrew and Buchanan and the Kansas county of Doniphan.

Dr. William G. Shepherd, a distinguished professor of economics, testified that if Dr. Willman was in fact affording his patients treatment at a medically acceptable level of quality, then his exclusion from the only hospitals in the geographic market had an adverse impact on competition in the general surgical services market. He also testified that the respondent hospitals, at least since their merger in 1984, had a monopoly in the market for acute hospital care services[3] and were facilities essential for a general surgeon to compete effectively in the relevant product and geographic markets.[4]

Four expert medical witnesses gave depositions on Dr. Willman's behalf. Drs. Jewell and Dunn, Kansas University Medical Center, and Dr. Roper, Washington University Medical Center, are distinguished professors of medicine. Dr. Miller is a Kansas City area board certified gynecologist. Each testified that Dr. Willman's care of his patients met acceptable medical standards.[5] Respondents presented evidence to the contrary in the form of their own peer review conclusions and the testimony of experts retained for trial.

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[3] The respondent hospitals were independent, sectarian institutions until 1984. These previously competitive hospitals acquired monopoly power in the St. Joseph area market in 1984 when they came under common ownership of Respondent Heartland Health Systems, Inc. Almost 90% of the hospitalizations of persons living in the market were provided by Heartland Health Systems, Inc.

Heartland Health Systems, Inc. and an organization of local doctors are currently under scrutiny of the Antitrust Division, U.S. Department of Justice for alleged monopolization, market allocation, and market foreclosure. *See* Kansas City Star, Dec. 8, 1994, at B1; St. Joseph News-Press, Dec. 9, 1994 at 1B.

[4] In addition to having a monopoly over acute hospital care, the respondent hospitals controlled access to the only surgical suites in the market -- facilities that are essential for competition in the market for general surgical services.

[5] Dr. Miller testified that Dr. Willman's treatment of certain gynecological patients met, but did not surpass, minimally acceptable standards.

The respondent physicians include the four board-certified general surgeons and six other doctors with whom Dr. Willman competed. Because of the breadth of his training, Dr. Willman competed to a certain extent with other specialists. For example, he competed for surgical patients with gynecologists and urologists by providing routine gynecological and female urological surgery services for which he was trained during his residency. Dr. Willman also offered diagnostic endoscopy services and facilities as part of his general surgical services.[6] For these services he competed with the hospitals and respondent Lockard who for a time was the only gastroenterologist in the area.

Dr. Willman also provided primary care services in competition with internists and family practitioners. He offered these services as a means of developing a self-referral source of surgical patients after the primary care physicians in St. Joseph stopped referring him surgical patients. These referral sources dried up after Dr. Willman, in a bitter eleven year litigation, successfully sued his former partner, respondent Beheler, for breach of a non-competition agreement. That action created tremendous resentment and hostility towards Dr. Willman in the St. Joseph medical community.

Although competition for patients was fierce, Dr. Willman was very successful. In 1980-81, for example, he saw as many as 4,000-5,000 patients per year. In contrast to his competitors, including respondents, he charged lower prices, provided routine services free, gave personalized care, and accepted patients on welfare.

B. The Role of Competitors in Dr. Willman's Peer Review.

1. Background. Dr. Willman's competitors, on three occasions prior to 1982, attempted to use the hospital peer review

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[6] Endoscopy is a procedure employing a flexible fiberoptic instrument by which a physician can visualize virtually the entire gastrointestinal system. It is used for diagnostic purposes as well as certain general surgical operative procedures.

process to exclude him from their markets by restricting his privileges. In 1976, competing internists on the Credentials Committee at Methodist Medical Center (MMC) tried to restrict his privileges to treat medical patients.[7]

In 1981, the Chairman of the Quality Assurance (QA) Committee at St. Joseph Hospital (SJH) sought to limit Dr. Willman's endoscopy privileges. The business partner of that committee chairman was respondent Lockard, a gastroenterologist and at the time the only other doctor in St. Joseph performing diagnostic endoscopies.

In October, 1981, competing gynecological surgeons on the SJH QA Committee asked the hospital to limit Willman's privileges to perform routine gynecological surgery.[8]

2. *The Initial Events.* The immediate events of this case began in February, 1982 when Dr. Willman successfully treated Bobby Fanning, a young man suffering a self-inflicted gunshot wound to the chest. His successful, early morning emergency room treatment was marred by the inability of the emergency room nurse to find a chest tube of the size called for by Dr. Willman. Subsequently and before even examining the patient, respondents Andres, Craig and Beheler, each a competing general surgeon, criticized the size and placement of the chest tube and Dr. Willman's care of the patient. They caused the administrator of MMC to convene a meeting of the Critical Care Committee

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[7] Methodist Medical Center (MMC) became Heartland Hospital West (HHW). St. Joseph's Hospital (SJH) became Heartland Hospital East (HHE). The name changes occurred in 1984 when the hospitals came under the common ownership.

[8] The use of peer review to restrict competition was not restricted to Dr. Willman. In 1980, the SJH Credentials Committee refused to credential a general surgeon seeking privileges to perform routine gynecological surgery for the reason that there were enough gynecologists already providing those services.

(CCC). That committee included respondents and other competitors, including respondent Beheler, the defendant in the rancorous 11 year litigation with Dr. Willman previously discussed.

At the urging of the three general surgeons, the CCC decided that Dr. Willman should relinquish care of the patient. Respondent Craig ordered Dr. Willman to turn care of his patient over to respondent Beheler or face immediate suspension. The patient's parents refused Beheler. Before examining the patient, Craig told the Fannings their son needed immediate chest surgery to correct a life-threatening condition. The parents then let Craig examine their son. Craig examined Fanning, made no significant change in Dr. Willman's treatment regime, and concluded that the patient was neither critical nor in need of immediate surgery. Subsequently, the patient was transferred to a Kansas City hospital where he underwent elective surgery.

Dr. Roper, a professor of thoracic surgery at Washington University in St. Louis, gave evidence that Willman's treatment of Fanning met acceptable medical standards. The defendants' expert, of course, disagreed.

Shortly after this incident, Allison, Administrator of MMC wrote:

> I have continued to stay in close contact with Dr. Richard Craig and Dr. Stuber regarding this matter. At this point it is uncertain what Dr. Willman's next step will be. *It does appear that there is complete support from the Medical Staff and the boards of both hospitals to pursue this as far as Dr. Willman would so desire.* (emphasis added)

In the same period, Dr. Willman overheard Beheler tell another doctor that they [the CCC] had "humiliated" Willman and that they were watching him to find other incidents which they could use against him. At another time, Beheler told a

hospital administrator "by the time I'm through with [Willman], he'll be bankrupt."

3. The Peer Review at Methodist Hospital. In early March, 1982, Dr. Willman found posted on a public bulletin board confidential minutes of the CCC criticizing his care of Fanning and recommending a review of his last 60 cases "with the idea of possibly having his privileges reduced or banned from practicing at this hospital."

Acting on this recommendation, the Medical Executive Committee (MEC) commenced an unannounced review of Dr. Willman's closed cases for 1981 and 1982. These reviews culminated in a finding by the MEC on January 18, 1983 that Willman's treatment of a number of patients fell below their standards. Eight of the thirteen participants in that meeting were competitors of Dr. Willman.

On January 24, 1983 the Executive Committee of the Board of Trustees recommended to the MEC that Dr. Willman submit to corrective actions, such as increased scrutiny of his charts and mandatory consultations. That recommendation was never carried out by the MEC.

The MEC, instead, convened an executive session on February 1, 1983 and suspended Dr. Willman's privileges effective immediately. Nine of thirteen participants in that meeting were competitors of Dr. Willman, including the Chief of Staff and Committee Chairperson, respondent McMillen.

The MEC had no authority unilaterally to suspend Willman effective immediately. McMillen tried to justify the action by citing a by-law provision that allowed the MEC and an Administrator jointly to suspend a physician in an emergency if re-

quired for immediate patient safety.[9] Since Dr. Willman had no acute care patients in the hospital at the time, no emergency could exist.

Four months later, when the MEC afforded Dr. Willman a hearing on his suspension, eleven of seventeen committee members participating were his competitors. Nine had taken part in the earlier meeting where his immediate suspension was approved. The hearing continued until 4:00 a.m., causing Dr. Willman's experts to leave without testifying because each had his own patient care obligations. The Committee would not adjourn and reconvene at a time more convenient for these witnesses. When the proceeding concluded, Dr. Willman's suspension remained in effect. Dr. Willman's experts would have given evidence (as they would have at trial) that the quality of Dr. Willman's care was acceptable.

In December, 1983 at the conclusion of his suspension, Dr. Willman reapplied for privileges at MMC. His application was sent to a newly-created committee, whose three members included respondents Craig and Andres.[10] The "Committee" recommended against Willman's application. Craig, as Chairman, also laid out conditions under which Dr. Willman's privileges might be restored. One condition was that Willman accept

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[9] Under the By-laws of both hospitals, revocation of a physician's privileges required two elements: (i) a recommendation from the medical staff, and (ii) action by the governing body. Neither medical staff had authority to act unilaterally nor did the boards. The By-laws of both hospitals also provided for summary suspension of a physician whenever *immediate* action was required in the interest of patient safety or care. The chief of staff with concurrence of the hospital administrator had the authority to suspend summarily for patient safety in an emergency, but no authority to revoke privileges.

[10] Craig, the chief of surgery, and Andres were the general surgeons who instigated the Fanning incident. *See* part B.,2., *supra.*

only surgical patients on referral like the other general surgeons.[11]

The Credentials Committee, with three competitors out of five members, the MEC, with eight competitors out of fourteen and, eventually, the MMC Board of Trustees followed Craig's and Andres' recommendation and ratified the refusal of his application.

4. The St. Joseph Hospital Peer Review. In Fall 1982, SJH began a series of investigations and committee actions that overlapped those being taken at MMC.[12] Respondent Weinand, a competing general surgeon, the Chief of Staff and Chairman of the MEC, appointed a special sub-committee to evaluate Dr. Willman's 1981 and 1982 charts. Three respondents (Weinand, Mullican, a competing internist, Lockard, a competing gastroenterologist) and Dr. Marston, a competing gynecological surgeon, comprised the committee.

Using the Methodist Hospital incident involving patient Fanning, the MEC took corrective action against Dr. Willman. Eight of nine committee participants were his competitors. At a hearing held to review the MEC's decision, Weinand, who appointed the hearing panel,[13] presented deceptive testimony about Fanning's condition and the recognized methods of treatment as set forth in standard surgical texts and the current medical literature. This was not the only occasion during the

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[11] More than once, other physicians suggested that Dr. Willman's primary care practice was at the root of his problems.

[12] Most physicians in the market had staff privileges at each hospital.

[13] One hearing officer was a doctor employed by respondents McMillen, Krueger and Stuber, each of whom had played a significant role in Willman's loss of privileges at MMC or in the Fanning incident. The latter two had voted for the action being reviewed. Another was a doctor employed by respondent Mullican, one of the special sub-committee members reviewing Dr. Willman's 1980 and 1981 charts.

peer reviews that one of the respondents used questionable medical evidence.[14]

At the April, 1983 meeting of the MEC, Dr. Weinand's special sub-committee reported on its review of Dr. Willman's closed cases. The MEC determined on the basis of that report to take corrective action against Dr. Willman. Ten of eleven participants were competitors of Dr. Willman.

On May 31 and June 7, 1983, the MEC held a hearing on the charges. Among other things, Weinand presented three statistical "audits" showing that Dr. Willman's post-operative infection, readmission and incisional hernia rates compared unfavorably with other doctors. Discovery revealed that the underlying data on which those audits were based was inaccurate or unreliable. At the conclusion of the hearing on June 7, 1983, the MEC revoked Dr. Willman's privileges effective immediately.

The MEC's unilateral action was unauthorized by hospital bylaws. Since the MEC had been contemplating its action for a lengthy period, it made no effort to claim or prove that an emergency existed.

The summary suspension of Dr. Willman by the MEC at MMC on February 1, 1983 and immediate revocation of his privileges by the MEC at SJH on June 7, 1983 exceeded the authority of each medical staff because i) each MEC acted

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[14] Weinand selectively edited quotes from standard surgical texts to include information favorable to his position while omitting crucial information favorable to Dr. Willman, particularly information that controversy surrounded the recommended treatment for such injuries. On other occasions Andres withheld evidence that there was substantial disagreement among surgeons, as disclosed by the medical literature, as to the proper treatment of a chest wound such as Fanning's. Each time Krueger testified, he reported a higher volume of residual material in Fanning's chest from the time before and misdescribed it as blood. There were other similar incidents involving other doctors.

unilaterally and ii) no emergency existed. Each action was done publicly, made effective immediately, bore the professional endorsement of the leaders of staff, and usurped the authority of hospital boards. Because of each boards' legitimate concerns over "corporate negligence," according to the evidence, the MECs' *fait accompli* effectively precluded either board from reinstating Willman, no matter how unwarranted the MEC's actions happened to be.

5. Dr. Willman's Attempts to Regain Privileges. In December, 1983, after being without hospital privileges since the previous June, Dr. Willman filed a mandamus action against SJH seeking restoration of his privileges. The circuit court entered a preliminary writ that enabled Dr. Willman to practice at SJH for fourteen months. Dr. Willman practiced at SJH without any complaint from other doctors, any staff committee or any patient. In March 1985 an appellate court vacated the writ and remanded with instructions to dismiss. Immediately upon learning the writ was vacated, SJH refused Willman access to the hospital.

Once again without hospital privileges, Willman, in March 1985, made application to MMC and SJH, which by this time were under common ownership.

Dr. Willman's application to Heartland Hospital East (HHE), formerly SJH, was referred first to the Surgical Credentials Committee. There three physicians, two of whom were his competitors, recommended denial of his application because he had not presented evidence of recent training and experience. The Committee gave no consideration to his 14 months of complaint-free practice. On August 19, 1985, the MEC, consisting of six competitors out of nine participants, followed that recommendation. Two days later, the Departments of Surgery of the hospitals held a joint meeting. A majority of the attendees were Willman's competitors. They also followed that recommendation.

At Willman's request, HHE convened an Ad Hoc Committee in early October, 1985 to review the MEC's action. The chairman of the hearing panel was a gynecological surgeon in direct competition with Willman. The other two members were internists also in direct competition with him for primary care patients. This panel also refused Dr. Willman's request to consider the hospital's own records of his 14 months of practice on the technical ground that he had the burden of producing the hospital's own records to its staff committees. That "ruling" was made by the chairman of the hearing panel on the advice of the hospital's attorney.[15] The MEC confirmed the action of the Ad Hoc Committee in October, 1985. Of eleven participants, seven were Dr. Willman's competitors.

At Heartland Hospital West (HHW), formerly MMC, the pattern of events was similar. A four person credentials committee that included respondent Weinand and two other competitors, voted to deny the application for reasons identical to those stated at HHE. The MEC adopted that decision in September, 1985. Of fourteen participants, eight were his competitors. In November, 1985, an Ad Hoc Hearing was convened at Dr. Willman's request. Of the nine members of the panel, six were his competitors and three were employees of respondents. None of these committees was willing to consider Dr. Willman's 14 months of complaint-free service as evidence of his medical qualifications.

6. The Evidence of Flawed Peer Review Proceedings. Dr. Willman presented testimony of a peer review expert that the refusal of the staffs to consider his 14 months of practice at HHE as evidence of his qualifications when considering his 1985 applications was indefensible as a medical matter and highly

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[15] The chairman already had access to and knowledge of Dr. Willman's surgical cases because he was also a member of the Surgical Case Review Committee whose routine function was to review the surgical cases of all doctors.

questionable as a legitimate interpretation of the by-laws. Without that data the hospital boards had little basis upon which to review the MEC's action had the Board possessed such independent capability, which it did not.[16]

Dr. Waite, the peer review expert, testified that both medical staffs conducted flawed and biased peer reviews throughout. The presence of competitors on key committees serving as both witnesses and judges was a particularly obvious shortcoming, but far from the only one. The type of review conducted, namely chart-based, was also flawed. A chart-based peer review is one based on closed patient charts. It cannot be conducted fairly, absent pre-existing, written standards of practice against which to measure a physician's actions. Neither hospital had such standards.

In the absence of standards, chart-based peer review, Dr. Waite testified, is wholly subjective, reflecting nothing more than the personal opinion of the reviewer, and is unreliable. Such reviews have little or no impact on patient safety or well-being. They are concerned chiefly with corrective action against the physician. Only concurrent or prospective reviews have any impact on quality of current patient care.

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[16] Hospital boards typically rely on their medical staffs for judgments about the quality of care in specific clinical situations. Evidence from a former Heartland administrator, two experts, and board resolutions establish that, while the hospital boards here exercised *de jure* decision-making authority on medical and credentialing matters, they were, *de facto*, dependent on the judgment of the medical staff in such matters. The hospital boards here were chiefly laypersons incapable of independently reviewing the judgments of the medical staff on medical issues or the qualifications of physicians. In fact, those boards always acquiesced in the judgment of the staff on such matters. While they examined peer review decisions to see whether the staff had followed prescribed procedures, they did not review the staff's professional judgments. Even the board's resolutions recite reliance on the judgments of the medical staff in arriving at their decisions on Dr. Willman.

Respondents imposed the severest possible sanctions on Dr. Willman, making it impossible for him to obtain hospital privileges elsewhere, although he has tried. Petitioner's peer review expert and his economist agreed that the respondents' sanctions were excessive, as compared to corrective action (or the lack thereof) meted out to other similarly situated physicians, and that other less restrictive means were available to respondents which would have satisfied legitimate health care quality goals.

Dr. Willman, on more than one occasion, indicated his acceptance of restrictions on his practice such as mandatory consultations and more frequent and comprehensive reviews of his active charts in order to regain hospital access. Respondents rejected these blandishments on various pretexts.

C. Course of Proceedings and Disposition Below.

At the conclusion of discovery, the respondents filed their motions for summary judgment. Petitioner filed its opposition accompanied by an appendix of approximately four to six thousand pages documenting the disputed facts. On October 19, 1993, the district court granted their motions, entered judgments for respondents on the §§1 and 2 Sherman Act claims and, declining to exercise supplemental jurisdiction, dismissed the remaining state law claims without prejudice. The opinion of the district court is set forth in Appendix B, A16.

On August 29, 1994, a panel of the Eighth Circuit Court of Appeals affirmed the district court. App. A, A1. While accepting "that the evidence creates a genuine issue as to whether the peer reviewers reached the wrong result, and, as a consequence, removed a qualified physician," the Court did not agree "that this factual issue precludes summary judgment." App. A, A8. The essence of the Court's reasoning is embodied in its holding that,

> An antitrust action is not the proper forum in which to evaluate a physician's competence. [citations omitted] . . . whether Willman actually provided substandard care is not

> the proper question. Rather, we must decide whether Willman's peer reviewers could have reasonably concluded that he provided substandard care." App. A, 8-9.

Citing *Johnson v. Nyack Hosp.*, 964 F.2d 116, 121 (2d Cir. 1992)[17], the Court concluded that corrective action against a physician does not violate the antitrust laws provided the physician's peer reviewers had legitimate medical reasons to believe that the physician provided substandard care. Only where the peer group's conclusions are "so baseless that no reasonable medical practitioners could have reached these conclusions after reviewing the same set of facts would the Eighth Circuit permit an inference of conspiracy. *Bolt v. Halifax Hosp. Medical Ctr.*, 891 F.2d 810, 821 (11th Cir. 1988) (subsequent history omitted)." App. A, A10.

The Court did not discuss the expert economic testimony that Dr. Willman's exclusion adversely impacted competition in the relevant market or that such impact was reasonable *only* if Dr. Willman rendered substandard care.

Since there were conflicting medical opinions regarding the acceptability of Willman's care, the Court found his exclusion from the hospital to be as consistent with the lawful motive of promoting quality patient care as with an anticompetitive motive. App. A, A10. Such conduct, without more, the court held, does not give rise to an inference of conspiracy. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 588 (1986); *Lovett v. General Motors Corp.*, 998 F.2d 575, 579 (8th Cir. 1993).

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[17] The Eighth Circuit misread *Johnson*. The *Johnson* Court found that a determination of a physician's competence was the dispositive issue in gauging the anticompetitive effects of a peer review action. 964 F.2d at 121. The *Johnson* Court, citing the doctrine of primary jurisdiction, concluded that such a determination should be made in the first instance by the appropriate state health care agency as provided by New York law. *Id.* at 122-23.

The Court considered but rejected Dr. Willman's contention that the record contains evidence from which to infer an antitrust conspiracy. The Court accepted the proposition that Dr. Willman's competitors "participated at every stage of the peer review process." However, it found "no evidence that the competitors acted in concert to pursue an unlawful motive." App. A, A11. The Court made no reference to or comment about Dr. Willman's countervailing evidence that respondents manipulated the evidence and proceedings to Dr. Willman's disadvantage as set forth at parts A and B, *supra*.

The Court further held that Dr. Willman presented no evidence to dispute the respondents' affidavits that the hospital boards, not the competing physicians, had the authority to make the final determination concerning Dr. Willman's privileges. The Court made no reference to or comment about countervailing evidence he presented that the hospital boards composed largely of laymen were incapable of independently assessing medical opinions of the staff. Consequently, the boards always deferred to the staff's decision as they did in this instance. *See* n. 16, *supra*.

REASONS FOR GRANTING THE WRIT

In direct conflict with recent decisions of this Court and another Court of Appeals, the Eighth Circuit held that Sherman Act challenges to medical peer reviews should not be subjected to a typical Rule of Reason analysis. Rather than weigh the competitive effects of the peer review decision, the Appeals Court found that the reviewers reasonably could have determined that Dr. Willman provided unacceptable care and that no reasonable inference of antitrust conspiracy could be drawn from evidence that his exclusion resulted from a sham peer review conducted by his competitors.

The Eighth Circuit opinion effectively exempts medical peer review, regardless of its circumstances or effects, from antitrust scrutiny and relieves hospitals and physician-reviewers from the well-settled requirements of Federal Rule of Civil Procedure 56 when seeking a summary judgment. If not reviewed and reversed by this Court, the Eighth Circuit's decision will erode this Court's century-long admonition that courts should not create common law exemptions to the antitrust laws and its recent reaffirmation in *Eastman Kodak v. Image Technical Services* that normal summary judgment rules apply to antitrust cases.

Peer review, the process by which physicians and hospitals evaluate and discipline staff doctors, has become an integral component of our health care system. Peer review is mandated by the laws of most states and by federal Medicare and Medicaid regulations. The consequences to a doctor of an adverse peer review by even one hospital could be "tantamount to excluding a doctor from the profession as a whole." Blumstein & Sloan, *Antitrust and Hospital Peer Review*, 51 Law & Contemp. Probs. 7, 52-53 (Spring 1988).

The consequences of the Eighth Circuit's decision extend far beyond the destruction of Dr. Willman's professional life by a competitor-driven peer review. The Court of Appeals' decision

that peer review is exempt from well-established Rule of Reason principles and equally well-settled summary judgment standards threatens an important safeguard of competition in the medical services industry. Congress has recognized the importance of continued antitrust scrutiny of peer review in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101-11152.[18] The Act provides peer reviewers limited immunity from antitrust damages, but only if the peer review is conducted by those "not in direct economic competition with the physician involved." *Id.* at §11112(b)(3)(A)(iii).

I. The Court Of Appeals' Refusal to Apply the Rule of Reason To Peer Review Directly Conflicts With Decisions Of This Court And Other Courts Of Appeals.

The Eighth Circuit decided this case from its perspective that "[a]n antitrust action is not the proper forum in which to evaluate a physician's competence." App. A, A9. This Court has come to the opposite conclusion in *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322 (1991) and *Patrick v. Burget*, 486 U.S. 94 (1986). Similarly, the Court has admonished lower courts not to create common law exemptions from the antitrust laws. *See, e.g., National Gerimedical Hospital v. Blue Cross*, 452 U.S. 378, 388-89 (1981).

In *Patrick*, this Court specifically rejected the notion that application of the federal antitrust laws would thwart effective peer review saying, "this argument, however, essentially challenges the wisdom of applying the antitrust laws to the sphere of medical care, and as such as it is properly addressed to the legislature." 486 U.S. at 105. In so holding the Court made quite clear that the full scope of the antitrust laws applies to medical care issues such as peer review proceedings.

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[18] The Act was enacted after the events at issue in this case and is not retroactive.

The Eighth Circuit's refusal to subject peer review to conventional antitrust analysis under the Rule of Reason is in direct conflict with the decisions of this Court. Rather than weighing the reasonableness of the impact on competition of a physician's peer review exclusion, the Eighth Circuit deferred to and accepted the peer reviewers' disputed findings of unsatisfactory care and held immaterial whether Dr. Willman in fact provided acceptable medical treatment. App. A, A8-9. This approach fails to consider whether the peer review was a pretext to stifle competition.

The Rule of Reason requires more. In the case of peer review, the anticompetitive effect of a physician's exclusion cannot be determined without an assessment of the quality of that physician's care. As Petitioner's economist testified, if Dr. Willman was providing acceptable care then his exclusion from the relevant market had an adverse impact on competition. His exclusion could be procompetitive only if he was providing unacceptable care and his exclusion was the least restrictive means to correct that situation.

Such an analysis is mandated by this Court's many Rule of Reason decisions. At its essence, the Rule of Reason inquiry is whether the challenged acts are "unreasonably restrictive of competitive conditions." *Standard Oil Co. v. United States*, 221 U.S. 1, 58 (1911). "The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Chicago Board of Trade v. United States*, 246 U.S. 231, 238 (1918); *accord National Society of Professional Engineers v. United States*, 435 U.S. 679, 690-92 (1978). A Rule of Reason analysis requires "the fact finder [to weigh] all of the circumstances of a case." *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 49 (1977). "[T]he purpose of the analysis is to form a judgment about the competitive significance of the restraint; it is not to decide whether a policy favoring competition is in the public interest, or in the interest of

the members of an industry. Subject to exceptions defined by statute, that policy decision has been made by the Congress." *Professional Engineers*, 435 U.S. at 692.

The Third Circuit applied the Rule of Reason to medical peer review in a decision that plainly conflicts with the Eighth Circuit's opinion in *Willman*. In *Miller v. Indiana Hospital*, 843 F.2d 139, *cert. denied*, 488 U.S. 870 (1988), the Third Circuit reversed a district court which held that "in order for a plaintiff physician to withstand summary judgment in an action arising out of a hospital's decision to terminate the physician's staff privileges, 'the plaintiff must demonstrate on the basis of the record before the hospital at the time of its decision, that the hospital lacked substantial evidence in support of its ultimate decision.'" 843 F.2d at 142. The Third Circuit stated that the district court's application of this "substantial evidence" test "effectively eliminates any application of the antitrust laws to [the reviewers'] actions. *Id.* at 143.

The *Willman* Court completely misapplied the Rule of Reason by sidestepping the issue of Dr. Willman's competence, even though the court conceded a dispute on that issue. Instead of determining whether the challenged peer review was anticompetitive because it excluded a competent physician-competitor, the Appeals Court disregarded the inquiry finding "it would not have been unreasonable for Willman's peer reviewers to have doubts about the quality of Willman's patient care" App. A, A9.

To justify its Sherman Act analysis, the Eighth Circuit relied on *Johnson v. Nyack Hospital*, 964 F.2d 116 (2d Cir. 1992). But rather than supporting *Willman*'s approach to the Rule of Reason, the *Johnson* decision confirms that "[w]hether defendants had a proper medical reason for terminating Johnson's privileges will be dispositive of his antitrust claims." 964 F.2d at 121. That question required an "evaluation of whether Johnson provided inadequate treatment to Nyack's patients." *Id.* at 122.

As a result of the denial of staff privileges to Dr. Willman, he cannot practice his specialty in the St. Joseph market or anywhere else because no hospital will grant him staff privileges. Indeed, the record shows that he was denied staff privileges at other hospitals outside the St. Joseph area. No one questions that the denial of staff privileges is tantamount to permanent exclusion from the market place. The Third Circuit in both *Weiss v. York Hospital*, 745 F.2d 786 (1984), *cert. denied*, 470 U.S. 1060 (1985) and *Miller* has made this clear.[19] The *Miller* Court noted that the absence of staff privileges is devastating to a physician such as a surgeon who depends to such a large degree on the technology and equipment found only in a hospital setting." 843 F.2d at 141 n.2.

Instead of the Rule of Reason analysis required by the Sherman Act, the *Willman* Court chose to apply the "substantial evidence test" rejected by *Miller*. As a consequence of accepting without further examination what the respondent peer reviewers could reasonably have concluded, the Appeals Court made no antitrust analysis at all. The Eighth Circuit's flawed approach denies physicians and patients alike the protection of the Sherman Act and increases the risk that competitors will use peer review as a pretext to eliminate their rivals. Medical competence or lack thereof is the touchstone by which the competitive impact of peer review exclusion must be measured. By refusing to accept this fundamental principle, the Appellate Court has retreated from the cardinal principle of antitrust analysis — the Rule of Reason — announced first by this Court in *Standard Oil* and reiterated and reaffirmed ever since.

Peer review can be either an effective means to guarantee quality health care or a devastating weapon in the hands of

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[19] *Accord Bolt v. Halifax Hospital Medical Center*, 891 F.2d 810, 820 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990) ("a negative decision at one hospital could effect the decision at another hospital; therefore, as the commentators have noted, a negative decision by one hospital 'could be tantamount to excluding a doctor from the profession as a whole'").

doctors and hospitals who use it for anticompetitive reasons. This case presents the Court with a significant opportunity to preserve the laudable aspects of peer review by enforcing the Sherman Act's existing constraints on that process.

II. The Court Of Appeals' Disregard of the *Kodak* Decision and Rule 56 In An Antitrust Case Warrants Review.

The Eighth Circuit upheld the district court's grant of summary judgment by disregarding *Eastman Kodak Co. v. Image Technical Services, Inc.*, 112 S.Ct. 2072 (1992) ("*Kodak*") and Fed.R.Civ.P. 56. Neither the Appellate Court nor the district court discussed the *Kodak* decision although that case and the issue of whether the evidence opposing summary judgment created a reasonable inference of conspiracy was squarely presented to both courts.

The Appeals Court acknowledged that whether Dr. Willman was a competent physician was in dispute. It also acknowledged that Dr. Willman presented evidence that his competitors participated at every stage of his peer review. App. A, A11. The Court omitted any mention of Dr. Willman's evidence that respondents used misleading evidence, disregarded by-laws, employed flawed methodologies, disregarded evidence of Dr. Willman's competence, and imposed unreasonable sanctions. Nevertheless, the Eighth Circuit found summary judgment appropriate based on its deference to and acceptance of the peer reviewers' disputed findings and its understanding that *Matsushita Electronic Indus. v. Zenith Radio Corp.*, 475 U.S. 574 (1986) ("Matsushita") requires more of an antitrust plaintiff than presenting evidence from which reasonable inferences can be drawn. App. A, A10.

In *Kodak*, the Court made clear that *Matsushita* did not introduce a special burden on plaintiffs facing summary judgment. *Kodak*, 112 S.Ct. at 2088. *Matsushita* "demands only that the non-moving party's inferences be reasonable in order to reach the jury." *Id.* at 2083. Further, *Matsushita* does not create

any presumption of summary judgment for the defendants. *Id.* at 2088.

Dr. Willman offered ample evidence from which reasonable inferences could be drawn as to the existence of a conspiracy, including that:

- Peer review is inherently concerted action and this instance was no exception.
- Willman's competitors dominated the peer review process; as such they had a rational economic motive to conspire.[20]
- The medical judgments reached were in dispute.
- Unreliable and misleading evidence was used in the peer review process; relevant evidence favorable to Dr. Willman was disregarded; by-laws and hospital board resolutions were disregarded.
- The peer reviewers applied flawed methodologies such as unwritten, discriminatory and subjective standards in terminating Dr. Willman for substandard practice; they failed to terminate similarly situated doctors.[21]

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[20] The involvement of competitors in excluding a rival from the market is sufficient evidence from which to infer a conspiracy. *See Monsanto v. Spray-Rite Service Corp.*, 465 U.S. 752 (1984); *Bolt v. Halifax Medical Center*, 891 F.2d 810, 820 (11th Cir. 1988), *cert. denied*, 495 U.S. 924 (1990) ("One of the first principles of economics is the inverse relationship of supply to price. If doctors in a hospital can exclude other doctors from practicing in that hospital, then obviously the remaining doctors can charge a higher price for their services.") *Cf. Gibson v. Berryhill*, 411 U.S. 564 (1973).

[21] The Third Circuit in a number of cases has held that the application of discriminatory standards in the peer review process by the hospital and its medical staff *cannot* have a procompetitive effect. *Miller v. Indiana Hospital* 843 F.2d 139, 144 n.7, *cert. denied*, 488 U.S. 870 (1988); *Weiss v. York Hospital*, 745 F.2d 786, 821 n.60 (1984).

- The respondents failed to employ the least restrictive alternatives.[22] Instead, Dr. Willman was totally amd permanently excluded.

- Because Dr. Willman was a satisfactory physician his exclusion had an unreasonable anticompetitive impact.

Instead of affording Dr. Willman all reasonable inferences arising from his evidence of conspiracy, the Appellate Court reached the curious finding that Dr. Willman's evidence was insufficient to show a "motive" to commit an antitrust conspiracy.[23] App. A, A8-11. Such an inapposite approach is contrary to the settled rule that once the restraint is shown to be "facially anticompetitive", plaintiff has satisfied the requirements of the Sherman Act and made out a prima facie violation of that Act. *Kodak*, 112 S.Ct. at 2088. The exclusion of a competitor by rivals "is facially anticompetitive and exactly the harm the antitrust laws aim to prevent." *Id.*; *see United States v. Griffith*, 334 U.S. 100, 107 (1948); *ES Dev., Inc. v. RWM Enter.*, 939 F.2d 547, 555 (8th Cir. 1991), *cert. denied*, 112 S.Ct. 1176 (1992) ("the exercise of veto power over a new franchise

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[22] *Wilk v. American Medical Association*, 895 F.2d 352 (7th Cir. 1990), *cert. denied*, 496 U.S. 927 (1990); *see generally* Blumstein & Sloan, *Antitrust and Hospital Peer Review*, 51 Law & Contemp. Prob. 7, 75-76 (Spring 1988).

[23] This Court long ago established that proof of either an unlawful purpose *or* an anticompetitive effect is sufficient to establish a violation of the Sherman Act. In *United States v. Griffith*, 334 U.S. 100, 105-06 (1948), the Court stated that an intent to restrain trade need not be proved. If the restraint flows from the natural consequences of the acts, the required causal nexus is present to establish a violation. In recent years, the Supreme Court has reaffirmed Griffith's rationale as applied to different factual situations. *See, e.g., National Collegiate Athletic Ass'n v. Board of Regents*, 468 U.S. 85, 101 n.23 (1984); *McLain v. Real Estate Board of New Orleans, Inc.*, 444 U.S. 232 (1980); and *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322 (1991). In this case, Dr. Willman presented evidence from an economist that his exclusion had an anticompetitive effect.

application by horizontal competitors constitutes a patently unreasonable restraint of trade."). In fact, respondents bore the "heavy burden" of competitively justifying their exclusion of Dr. Willman. *See National Collegiate Athletic Ass'n v. Board of Regents*, 468 U.S. 85, 113 (1984).

The Eighth Circuit's failure to consider Dr. Willman's evidence of his competitors' involvement, their unjustifiable actions, and the anticompetitive effects of their acts also conflicts with the Third Circuit's opinion in *Miller v. Indiana Hospital*. There, evidence of a much less egregious nature was held to be sufficient to establish an antitrust conspiracy. The evidence in *Miller* was that: 1) the hearing process involved conflicts of interest; 2) the defendant hospital had concerns about competition from the plaintiff prior to concerns about plaintiff's competence; and 3) the defendants failed to terminate other doctors whose infractions were more serious than plaintiff's. 843 F.2d at 144. As the *Miller* Court noted, "Congress has given the jury the responsibility of resolving disputed fact issues." *Id.* at 143.

The legacy of *Matsushita* has been confusion about appropriate summary judgment standards. The Eighth Circuit, even after *Kodak*, failed to recognize that *Matsushita* only means that the inferences a party draws from evidence must be reasonable.

CONCLUSION

For the foregoing reasons petitioner respectfully requests that this Court grant a writ of certiorari to the United States Court of Appeals for the Eighth Circuit.

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Dated: January 26, 1995.